Wren Systems

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Mar/19/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
L3-S1 laminectomy and discectomy and fusion at L4-S1 with bone growth stimulator implant (63042, 63044, 22612, 22614, 62290, 69990, 22842, 22851, 20938, 20975, 22325, 22558, and 63685)

DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
M.D., Board Certified Orthopedic Surgeon
Board Certified Spine Surgeon

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

[X] Upheld (Agree)
[ ] Overturned (Disagree)
[ ] Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW
Adverse Determination Letters, 2/10/10, 2/22/10
M.D., P.A. 2/2/10 to 12/9/08
M.D. 1/18/10 to 3/18/09
Radiology 1/8/09
Chiropractic Pain Center 10/10/08
M.D. 10/8/08 to 7/29/08
8/11/04
Diagnostic Imaging 1/13/05
Medical 8/7/04
2/10/10, 2/22/10
M.D. 9/19/09

PATIENT CLINICAL HISTORY SUMMARY
This is an injured worker who has undergone previous treatment using epidural steroids, spinal cord stimulator lead trials, and multiple medications. Records indicate he remains symptomatic. The medical records indicate a desire to form a fusion at L4/L5 and L5/S1 with laminectomy at L3/L4. However, the request was simply for the laminectomy. The patient is stated to have instability of 11 degrees with flexion/extension at L4/L5.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION

This patient's most recent MRI scan with and without gadolinium shows no findings whatsoever. There is a mild disc bulge at L3/L4. Previous MRI scan was also normal. A post CT discogram revealed an annular tear at L5/S1, partial tear at L4/L5, and a normal L3/L4 disc. The level of instability of 11 degrees of flexion/extension at L4/L5 does not meet the AMA Guidelines for instability, and hence, fusion would not be indicated as per the evidence-based ODG Guidelines and Treatment Guidelines. The request for laminectomy at L3/L4 in the absence of radiculopathy or any hard findings on MRI scan does not satisfy the ODG guidelines, as this request certainly appears to be in conflict with the imaging studies presented. Furthermore, there is no evidence of neurologic deficit to warrant the type of procedure recommended. It is for this reason the previous adverse determination could not be overturned. The reviewer finds that medical necessity does not exist for L3-S1 laminectomy and discectomy and fusion at L4-S1 with bone growth stimulator implant (63042, 63044, 22612, 22614, 62290, 69990, 22842, 22851, 20938, 20975, 22325, 22558, and 63685)

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

[ ] ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

[ ] AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

[ ] DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

[ ] EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

[ ] INTERQUAL CRITERIA

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

[ ] PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

[ ] TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

[ ] TEXAS TACADA GUIDELINES

[ ] TMF SCREENING CRITERIA MANUAL

[ ] PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

[ ] OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)